



2010

**OFFICE OF THE INSPECTOR GENERAL
ANNUAL REPORT**

Nicholas Kramer
Acting Inspector General

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LETTER FROM THE OFFICE OF INSPECTOR GENERAL

February 2010

Dear Reader:

This annual report has been prepared by the Kansas Health Policy Authority (KHPA) Office of Inspector General (OIG) pursuant to the requirements of K.S.A. 75-7427 and is respectfully submitted to:

- Honorable members of the Kansas Health Policy Authority Board
- Andrew Allison, PhD, Acting Executive Director of the Kansas Health Policy Authority
- The Honorable Mark Parkinson, Governor of the State of Kansas
- Honorable members of the Kansas Senate's Committee on Ways and Means
- Honorable members of the Kansas House of Representatives' Committee on Appropriations
- Honorable members of the Kansas Legislature's Joint Committee on Health Policy Oversight
- Ms. Barbara J. Hinton, Legislative Post Auditor
- The people of the State of Kansas

This report provides a history of the KHPA OIG and describes the OIG's accomplishments in fiscal year 2009 and the first half of fiscal year 2010. It also provides general statistics on provider billing, payments and sanctions submitted to us by the Kansas Department on Aging, Kansas Social and Rehabilitation Services and the Kansas Health Policy Authority.

I am fortunate to have recently assumed the position of Acting Inspector General at KHPA. Although the last year was one fraught with challenges, we are already making great strides in solidifying our plans and enhancing our work processes. We are poised to provide excellent service to our stakeholders in the coming year through performance auditing, program reviews and investigations.

We hope this report provides you with valuable information and we welcome any questions or comments you may have regarding the report contents or our operations. Please feel free to contact our office at OIG@khpas.gov or (785) 296-1076.

Sincerely,

Nicholas Kramer, CPA, CIA, CISA
Acting Inspector General

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INTRODUCTION TO THE OFFICE OF INSPECTOR GENERAL

The Kansas Health Policy Authority (KHPA) Office of Inspector General (OIG) was created by the 2007 Kansas Legislature as part of a much larger health reform bill, commonly referred to as Senate Bill 11. This creation of an independent oversight body, with the responsibility to review and investigate KHPA's performance in delivering health services, was a significant step in reforming public health care in Kansas.

The KHPA OIG, whose enabling statute is K.S.A. 75-7427, is the first statutorily created Office of Inspector General in Kansas. Its mission is:

- to provide increased accountability and integrity in KHPA programs and operations;
- to help improve KHPA programs and operations; and
- to identify and deter fraud, waste, abuse and illegal acts in the State Medicaid Program, the MediKan Program and the State Children's Health Insurance Program.

To fulfill its mission, the KHPA OIG conducts:

- *Investigations of fraud, waste, abuse, and illegal acts by KHPA or its agents, employees, vendors, contractors, consumers, clients, health care providers or other providers.* Investigations attempt to determine the extent of reported incidents, the amount of loss, and what weaknesses may have existed that led to the allegations/incidents. Investigative reports may make corrective action recommendations intended to avoid similar problems in the future. The OIG conducts investigations that are consistent with the principles and quality standards set out for investigations by the Association of Inspectors General (AIG). Topics for OIG investigations are identified by audit work performed by OIG staff as well as referrals from KHPA staff, legislators and the general public. The results of investigations are reported to KHPA management and are referred, if necessary, for further investigation or prosecution to the Kansas Attorney General.
- *Audits of the KHPA, its employees, contractors, vendors and health care providers.* Audits are formal evaluations of an organization, its systems, processes, projects or products. Performance audits examine the effectiveness or efficiency of a program or operation. The overarching goal of all OIG audits is to review the quality of KHPA programs and processes and make recommendations for improvement. The OIG conducts its audits in a manner consistent with generally accepted government auditing standards developed by the U.S. Government Accountability Office (GAO). OIG audit topics are identified through periodic risk assessments, requests by the KHPA Board members, suggestions by KHPA management, suggestions from members of the Legislature, or from OIG audit staff.
- *Reviews, which may also be called inspections or evaluations.* Reviews are inquiries into a specific programmatic aspect of KHPA's operations. Reviews may attempt to determine many issues, such as whether a component of the program is effective and efficient or whether the program component has good strategies to safeguard the

appropriate use of state funds. Like investigations, the OIG will conduct reviews which are consistent with the principles and quality standards set out for inspections, evaluations and reviews by the Association of Inspectors General (AIG).

The results of all audits are presented in formal, written audit reports and through oral testimony to the KHPA Board and KHPA management. Draft audit reports are presented initially to the Finance and Audit Committee of the KHPA Board of Directors. Final audit reports are presented to the KHPA Board of Directors and are distributed to the Legislative Division of Post Audit and the Attorney General. Members of the Kansas Legislature, Kansas citizens and other interested parties may access audit reports, annual reports and other information on our website at <http://www.khpa.ks.gov/OIG/default.htm>.

As required by K.S.A. 75-7427, the KHPA OIG will report findings of fraud, waste, abuse or illegal acts to KHPA and also refer those findings to the Attorney General.

ORGANIZATIONAL STRUCTURE

As required by K.S.A. 75-7427 and amended by House Bill (HB) 2578, the Inspector General reports functionally to the KHPA Board and administratively to the KHPA Executive Director. Even though the Inspector General and the OIG employees are part of the Kansas Health Policy Authority, this organizational structure helps assure that the OIG achieves independence through freedom from organizational impairments. Kansas law includes several statutory provisions that promote objectivity in the OIG's oversight of KHPA programs and operations. Those provisions include:

- The Inspector General reports directly to the KHPA Board, which is a statutorily created governing body whose members are independently appointed and come from outside the organization.
- The Inspector General is selected by the KHPA Board, but the appointment must be confirmed by the Kansas Senate.
- The position of Inspector General is a classified position, and therefore, the person in that position has all the job protections offered by the Kansas Civil Service Act, including that he or she can only be removed for cause.
- As prescribed by the statute, appropriations for the office of inspector general are made to the KHPA “. . . by separate line item appropriation for the office of inspector general,” which further supports the independence of the office.
- The OIG provides an annual report of its activities to entities outside of the KHPA, including the Governor, three legislative committees, and the Legislative Post Auditor.

OFFICE OF INSPECTOR GENERAL STAFF

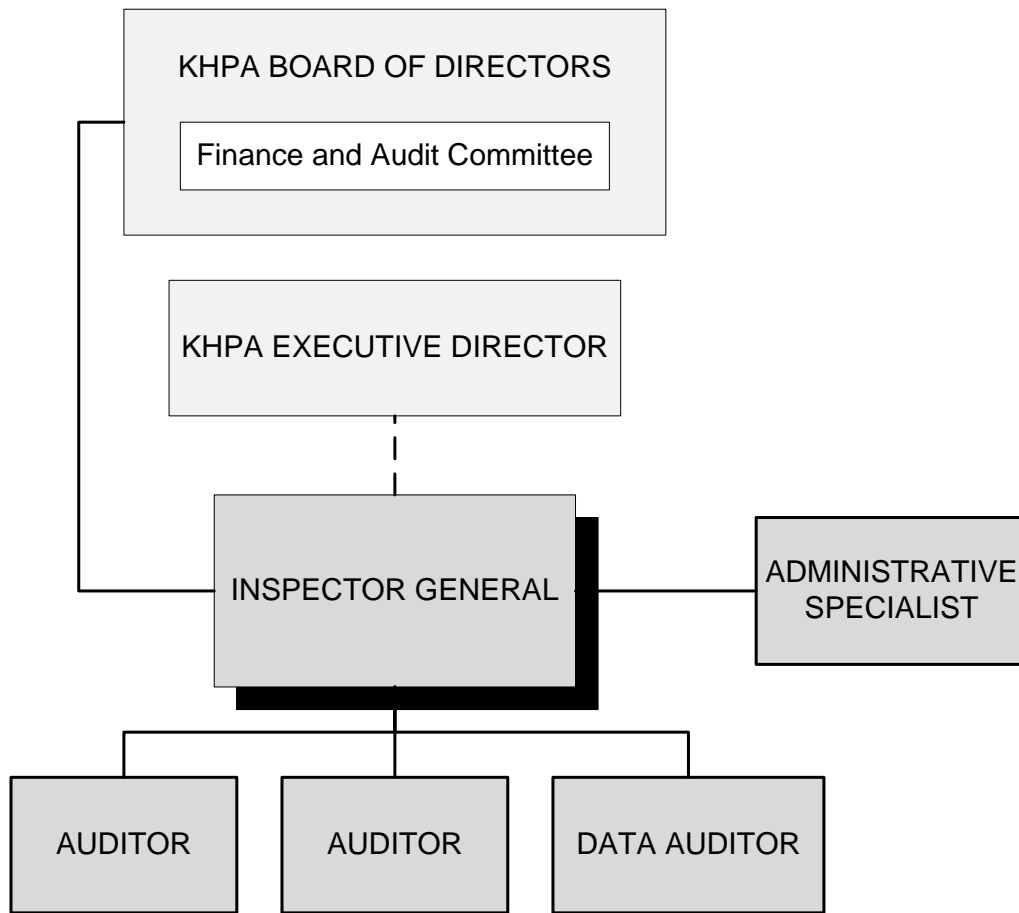
Nicholas M. Kramer was appointed Inspector General by the KHPA Board in September 2009. Mr. Kramer served as the Internal Audit Manager for the Kansas Department of Revenue for 25 years. In a previous role, he conducted financial and performance audits for the Kansas Legislative Division of Post Audit. His professional certifications include Certified Public Accountant, Certified Internal Auditor, and Certified Information Systems Auditor. Mr. Kramer earned his undergraduate degree in Accounting from the University of Kansas and his Master of Business Administration from Washburn University.

Felany Opiso-Williams is a Certified Internal Auditor. Prior to joining the OIG in 2008, she was an auditor for the Kansas Legislative Division of Post Audit. She received her Master of Public Administration and Certificate in Public Finance from Wichita State University, where she was a George Van Riper Fellow. Her undergraduate degree is in Accounting.

Stephen Mhere joined the OIG as Data Auditor in 2008 after serving as a Management Systems Analyst for the Kansas Department of Revenue. His degrees include a Bachelor of Science in Chemistry, Bachelor of Science in Computer Science, and a Master of Business Administration.

Kimberly Epps served at the Kansas Division of Emergency Management before joining the OIG as Administrative Specialist in 2008. She attended William Jewell College in Liberty, Missouri.

ORGANIZATIONAL CHART



ACTIVITIES AND ACCOMPLISHMENTS

The OIG begins the year 2010 with a new Acting Inspector General, Nick Kramer. We are now well positioned to expand our efforts to combat fraud, waste, abuse and illegal acts. By relying on the hard work of OIG staff and the cooperation of KHPA management, we will work to fulfill our mission of providing increased accountability and integrity in KHPA programs and operation. Our goal continues to be helping to improve KHPA programs and operations, and identifying and deterring fraud, waste and abuse in the state Medicaid program, MediKan and the State Children's Health Insurance Program.

The KHPA OIG conducts audits as approved by the Finance and Audit Committee of the KHPA Board, and conducts investigations and limited scope reviews based on complaints received from the public, referrals from legislators and the KHPA Board, and issues identified by KHPA management and OIG staff. During FY 2009, the KHPA OIG completed the following audits and reviews.

FISCAL YEAR 2009 ACCOMPLISHMENTS

AUDITS

Performance Audit of the Medicaid Home Health Fee-for-Service Program

The Medicaid Home Health Fee-for-Service (FFS) program is a component of the Kansas Medicaid program, which provides medical services to low income Kansans. In the FFS program, KHPA pays providers directly for the services they provide to eligible beneficiaries. This audit report answers the question: *Do the Kansas Health Policy Authority (KHPA) policies and procedures for the Home Health Fee-for-Service program promote good stewardship of government funds?*

Auditors found that KHPA is actively managing its Home Health Fee-for-Service program, but could improve efforts in fraud prevention, ensuring appropriate and accurate payments, and cost savings. Other audit findings include:

- KHPA staff does not review consumers' written plans of care, unless the case requires prior authorization or the home health agency (HHA) is subject to an audit by KHPA. A consumer's plan of care (POC) identifies medically necessary services for the consumer and should be signed by a physician. Reviewing consumer POCs ensures only medically necessary services are provided to consumers.

KHPA management said the planned expansion of prior authorization for all home health services, coupled with existing documentation requirements, is sufficient to address the OIG's concerns.

- Auditors reviewed 10 prior authorized claims paid in FY 2007 and found the number of service units claimed within the period exceeded the frequency or duration of services

prescribed in the consumers' POCs. KHPA staff told auditors an existing MMIS edit ensures an HHA cannot bill in excess of the total number of units allowed for the prior authorized period. However, the MMIS prior authorization edit does not screen for HHAs that bill in bulk for services that may not yet have been provided. Checking the reasonableness of the number of service units HHAs bill helps ensure only services actually provided are paid.

KHPA management said they will re-examine KHPA's prior authorization process.

- Providers are allowed to bill only full units of service. One unit of service is 15 minutes. If 16 minutes of service is provided, an HHA bills for two full units. This imprecise method of billing allows an HHA to increase its reimbursement by spending one more minute with a consumer than is necessary. Requiring HHAs to bill for partial units based on the actual amount of time service is provided should discourage providers from submitting excessive claims.

KHPA management concurs with this recommendation and plans to implement it in concert with other reforms.

- Auditors reviewed home health claims in FY 2004-2007, and identified seven HHAs that billed for services using more than one provider number. KHPA currently does not have an easy way to track all the numbers associated with one provider. This issue was identified by the Centers for Medicare and Medicaid Services (CMS) when it reviewed and certified the current MMIS. To address the issue, CMS suggested the fiscal agent create a cross reference table to track all numbers associated with a provider. Auditors agree with CMS' recommendation.

KHPA management concurs with this recommendation and will work with the fiscal agent to create a table in MMIS to cross reference provider identification numbers.

- Auditors found the fiscal agent does not immediately deactivate old provider numbers. If a provider changes its federal employer identification number (FEIN) due to a change in ownership or structure, KHPA issues a new provider number but relies on the provider to request the old number be deactivated. If no request is received, the provider number is turned off after 18 months of inactivity. Waiting a full 18 months to deactivate old numbers creates an opportunity for providers to submit duplicate claims without being discovered by MMIS. Auditors recommend KHPA turn off old provider numbers promptly. If needed, KHPA should create a method to allow for the payment of claims billed under the old provider number.

KHPA management concurs with this recommendation.

Cost savings associated with auditors' findings have not been quantified due to the extensive file review that would be required. The KHPA OIG released this audit report in October 2008. The complete audit report, including management's response, can be accessed on the KHPA OIG's website at <http://www.khpa.ks.gov/OIG/default.htm>.

REVIEWS

Review of the Medicaid Commercial Non-Emergency Medical Transportation (C-NEMT) Program

The KHPA OIG received a complaint from a member of the public alleging KHPA does not send provider manual amendments to providers and requires unnecessary use of private health information.

The OIG found that KHPA complied with its contract requirement to notify providers of amendments to the provider manuals. However, instructions on how to obtain a copy of the amendments have been inconsistent. According to KHPA management, after KHPA awarded the Kansas Medical Assistance Program (KMAP) fiscal agent contract to Electronic Data Systems (EDS) in 2003, a decision was made by KHPA to move the notification process for providers from a hard copy format to a web-based system. To accomplish this transition to web-based notification, the process for bulletin notifications has evolved over time. KHPA management said if they continue to receive comments from providers with regard to this issue, KHPA will plan additional communications to clarify this process with all enrolled providers.

The OIG also found that the use of private health information (PHI) on the form which justifies the medical necessity of providing NEMT services greater than 50 miles would likely be considered allowable under HIPAA exceptions. Nonetheless, auditors suggested C-NEMT providers make reasonable efforts to use, disclose, and request only the minimum amount of PHI needed to accomplish the intended purpose. According to KHPA management, the information noted on the medical necessity form is required to determine whether the NEMT request meets criteria for coverage, and thus ensure access to medically necessary transportation services for Medicaid beneficiaries. Furthermore, management said KHPA cannot use Medicaid funds to reimburse transportation costs unless required conditions are met.

Review of the State Employee Health Benefits Plan's HealthQuest Mail Outreach Process

The KHPA OIG received a complaint from a member of the public alleging KHPA's state employee wellness program (HealthQuest) may be wasting state dollars by sending unnecessary letters. KHPA's contractor, Health Dialog, sends the following types of correspondence to state employees: welcome letter, chronic condition letter, chronic condition gap letter, seasonal allergy letter, flu shot reminder postcard, and sensitive condition letter.

The OIG found that KHPA and Health Dialog limit waste related to HealthQuest correspondence by tailoring correspondence to employee health profiles. However, auditors recommended KHPA monitor whether other individuals enrolled in HealthQuest are receiving unnecessary correspondence, and if the number of health profile inaccuracies appear significant, KHPA may want to address this issue with Health Dialog. KHPA management agreed with the OIG's findings and recommendations.

Review of KHPA's Online Process for Submitting Claims with Associated Provider Write-Offs

The KHPA OIG received a complaint from a member of the public who received a recoupment letter from KHPA. The complainant alleged the online claim form does not have a field for disclosing third party provider write-off amounts, and the claim submission webpage and provider manuals do not give clear instructions on how to submit claims with associated provider write-offs.

The OIG auditors found that KHPA's online Medicaid claim forms do not provide a separate field for providers to enter contractual write-off amounts. Furthermore, while the third party provider manual clearly requires providers to disclose contractual write-off amounts, it fails to provide specific instructions on how providers may correctly submit online claims with associated contractual write-offs. The OIG noted that KHPA already started the process for correcting this problem in November 2008. According to management, KHPA may [inadvertently] pay the contractual write-off amount only when the Medicaid allowed amount is higher than the third party liability amount. Management said this is only a small portion of claims. Furthermore, management said once KHPA's new policy nears implementation, information will be published and distributed to providers and the manuals will be updated to explain the new process.

Review of KHPA's Work Opportunities Reward Kansans (WORK) Program

The KHPA OIG received a complaint from a member of the public who expressed concern that:

- Beneficiaries and personal care providers may have colluded to bill Medicaid for extra hours of personal care and split the payments.
- Policies that allow beneficiaries to pay directly for services they receive may be vulnerable to fraud.

Auditors did not attempt to obtain evidence to determine whether collusion exists between beneficiaries and attendant care providers, but reviewed KHPA's policies and internal controls to determine whether KHPA:

- Provides adequate oversight of beneficiaries who receive money and pay attendants directly for services.
- Has appropriate internal controls to preclude overbilling and improper payments that may be due to fraudulent activities such as collusion.

Auditors found that KHPA provides reasonably adequate oversight of WORK participants/beneficiaries acting as their own fiscal agent and paying their attendants directly for personal care services. However, oversight can be improved by implementing federally required compliance and financial reviews. Management agrees that periodic financial reviews, subject to available resources, will serve as a best practice for ensuring the long-term integrity of the WORK Program.

Auditors also found that KHPA has internal controls to prevent or identify overbilling of personal services. For example, the WORK Program Manager reviews participants' monthly allocation reports, and participants are required to submit timesheets, certified as accurate by both the participant and his/her personal attendant, before personal services are paid. However, KHPA could strengthen these internal controls. Auditors made several recommendations, including:

- Adding language on the timesheets stating that times reported by participants and their attendants are for "actual hours worked."
- Conducting reviews of participants' accounts and related documentation to help ensure paid hours do not exceed the monthly allotted hours in participants' individualized budgets.
- Verifying that individuals acting as participants' representatives do not perform attendant care services for the participants they represent.

Management agreed to add the recommended language to the timesheets regarding actual hours worked and review all current files to ensure that participants' representatives do not provide personal services. One possible exception would be for participants in rural western Kansas who may have difficulty finding personal attendants who are not the participants' representatives. Management noted that hours billed in excess of allotted hours may not necessarily indicate misuse. When misuse occurs, the fiscal agent will notify the WORK Program Manager and the participant, and corrective action will be taken.

Review of the Medicaid Provider Recoupment Process

The KHPA OIG received a letter from a Medicaid provider alleging it is not appropriate for KHPA to recoup money from a provider employed by a healthcare facility whose questionable billing practices are the subject of recoupment.

Upon signing the KMAP provider agreement, providers accept full liability for the truth, accuracy and completeness of all claims submitted for payment using their assigned provider numbers. Management agrees with this conclusion. For the particular provider number OIG staff reviewed, the provider signed the provider agreements in his name and in the name of the healthcare facility where he was employed.

The OIG found that KHPA could do more to ensure providers understand their responsibilities and potential liabilities as KMAP providers and to minimize overpayments. KHPA's provider enrollment manager or appropriate staff should ask providers to read the terms of the provider agreement carefully and explain the terms, if necessary, prior to accepting the provider agreement. According to KHPA management, they believe that given current resources, as much education as possible is given to providers regarding their responsibilities and potential liabilities. In light of continuing budget reductions it is unlikely that additional focus will be given to providing more personalized education.

KHPA should also consider adding language in the provider agreement to clarify the respective

responsibilities and liabilities of the provider and the owner of the healthcare facility or business entity that employs the provider. This may include the extent of the provider's responsibility and liability for:

- All services provided and all claims filed using his/her provider number regardless of who receives the payment.
- The conduct of the employer if the provider knew or reasonably should have known of the conduct, i.e. questionable billing practices, or if the conduct was effected with the provider's knowledge and consent.
- The use of his/her provider number to bill Medicaid for services actually provided by another provider or a provider not enrolled in KMAP or other improper arrangements involving provider compensation.

Furthermore, the OIG recommends KHPA ensure program managers promptly update the provider manuals to comply with applicable federal requirements in order to minimize overpayments and State refunds of the federal share of overpayments. According to KHPA management, the complete provider agreement, a summary of changes and frequently asked questions may be accessed on the KMAP website.

OTHER ACTIVITIES

Other accomplishments of the OIG in FY 2009 include the following. OIG staff:

- Attended 15 audit, review and investigation trainings.
- Attended 25 program integrity related meetings and conferences.
- Developed performance measures for the OIG portion of the KHPA strategic plan.
- Attended hearings on SB 141 (a bill to relocate the OIG to another state agency).
- Presented training along with SURS and MFCU at KHPA's Medicaid training session.
- Attended Finance and Audit Committee and KHPA Board meetings.
- Maintained day-to-day operations until a new Inspector General was hired 11 months after the previous Inspector General's departure.

FISCAL YEAR 2010 ACCOMPLISHMENTS TO DATE

AUDITS

Performance Audit of Kansas' Medicaid Claims Processing

Medicaid paid more than \$1.3 billion dollars to provide medical assistance to uninsured low-income Kansans in FY 2009 through programs administered by KHPA. About 66 percent of the funds or almost \$880 million was expended by KHPA through the Fee-for-Service (FFS) program, which pays providers directly for services to Medicaid beneficiaries. KHPA's fiscal agent processes these provider payments and is contractually required to ensure claims are accurate and processed timely.

This audit addresses the following questions:

1. How does KHPA oversee its fiscal agent's claims processing?
2. Is KHPA's oversight effective to ensure fiscal agent compliance with contractual obligations and federal requirements related to timeliness and accuracy of payments?

The OIG found that KHPA's Medicaid claims processing oversight is reasonably effective in ensuring the fiscal agent's timely processing of claims. However, we have five recommendations for KHPA management to consider, which could provide further assurance that claims will be processed in a timely manner and in accordance with contractual requirements.

1. The OIG recommends KHPA consider including an indicator for clean and non-clean claims in MMIS at the point of adjudication. Without this indicator, it is difficult to assess whether the fiscal agent met current timeliness standards.

KHPA management agrees with this recommendation. However, instead of creating an indicator, KHPA will create a specific data request for the HP Quality Assurance team that will pull the claims into the two categories requested, clean and non-clean claims. According to KHPA management, this approach will accomplish the intended outcome of the OIG's recommendation and be a less costly solution than creating an additional data element.

2. The fiscal agent's internal quality assurance audits show the fiscal agent did not meet timely claims processing standards from FY 2005 to FY 2008, but met new standards in FY 2009. KHPA took steps to resolve the issue in May 2008 when they changed the contract standard to accommodate longer processing times for newborn and non-emergency medical transportation (NEMT) claims, as well as adjustments.

The OIG recommends KHPA ensure the fiscal agent quality assurance team's process for calculating the percentage of aged claims agrees with current contractual timeliness

standards.

KHPA agrees with this recommendation. By creating a specific data request for the HP Quality Assurance team that will pull the claims into clean and non-clean claims as recommended above, KHPA will be able to implement this recommendation.

3. KHPA did not assess damages on the fiscal agent for not meeting claims processing timeliness standards since the beginning of the contract period. KHPA has a penalty clause in its fiscal agent contract, which states the fiscal agent shall be assessed one dollar per business day for each claim not processed within the required time frame. Had KHPA assessed damages on the fiscal agent for the aged claims identified in our sample, damages would have amounted to almost \$1.0 million in FY 2005. However, the amount of potential liquidated damages decreased to less than \$40,000 in FY 2006. Potential liquidated damages for FY 2007 and FY 2008 were significantly less at about \$3,400 and \$7,700, respectively. Damages would be higher if based on the actual number of aged claims KHPA staff identified which is more than eight times the number of aged claims in our sample.

According to KHPA staff, because resolutions and timeframes for correction were agreed upon by KHPA and the fiscal agent, and met by the fiscal agent, KHPA deemed it unnecessary to assess damages for not meeting claims processing timeliness standards.

The OIG recommends KHPA develop a guidance policy clarifying KHPA's position, and defining criteria under which damage assessment on the fiscal agent for not meeting contractual timeliness standards will be imposed or waived. This policy would ensure consistency in decision making.

KHPA said they will develop a general guidance policy that will establish criteria under which damage assessments will be imposed or waived when a contractor fails to fulfill its contractual requirements.

4. The OIG recommends KHPA staff review the timely filing exceptions listed in this report, and where appropriate initiate recoupment. Staff should also review timely filing procedures to minimize exceptions and ensure compliance with federal requirements.

KHPA agrees that Federal Regulation 42 CFR 447.45 seems to direct states to require providers to submit all claims no later than 12 months from the date of service. However, the regulation then establishes exceptions for payment of the claims past the 12 months. According to KHPA management, the regulation is ambiguous and the common interpretation among states and federal agencies has been that exceptions to the timely filing are allowable. KHPA does not plan to implement this recommendation to recoup payments from providers. However, KHPA will continue to closely monitor that only those claims that meet the qualifying criteria to be filed beyond the 12 months limit are considered for payment.

5. The OIG recommends KHPA legal staff review whether exemptions to the federal timely filing requirement allowed by K.S.A. 39-708a comply with federal law.

According to KHPA legal staff, K.S.A. 39-708a(b) is not, on its face, inconsistent with 42 C.F.R. 447.45 (d)(1). The basic issue concerns federal regulatory pre-emption of state statutes. Moreover, legal staff said any possible pre-emption is mitigated by:

- a) an ambiguous federal Medicaid regulatory subsection that does not match with the federal Medicaid statutory basis for the regulation;*
- b) a long-standing state statute which has never been questioned by federal auditors;*
and,
- c) a state statute that does not limit itself to Medicaid but covers payments by the state from any source.*

The OIG also conducted testwork in regards to the accuracy of Medicaid claims processing and found KHPA's oversight is reasonably effective in ensuring the fiscal agent's claims processing accuracy. However, claims processing overpayments remain a risk. Auditors found that some overpayments appear to slip through claims processing controls. While KHPA has supplemental controls, such as the SURS process and KHPA's pay and chase procedures, we are including three recommendations for KHPA management to consider. These recommendations could provide further assurance that claims will be processed accurately and in accordance with contractual requirements.

6. We found 14 claims totaling \$2,397 that do not meet gender restrictions. This means claims were paid on males for female procedures or vice versa. We reviewed 11 procedure codes with gender restrictions, analyzed related claims data from FY 2005 to FY 2009 and found Edit 4035 did not appear to prevent processing even if these claims did not meet gender restrictions.

We found 243 claims totaling \$24,811 that do not meet age restrictions. We reviewed 22 procedure codes with age-specific restrictions and analyzed related claims data from FY 2005 to FY 2009. We found Edit 4034 did not always prevent a claim from being paid even if the beneficiary's age does not match the age limitations for the procedure restrictions or covered benefit restriction.

We found 154 claims totaling \$19,080 for services which appear to have been provided after the beneficiaries' death. We provided KHPA staff with a list of claims for services that were supposedly rendered after the beneficiary's date of death. SURS staff subsequently initiated recoupment for 152 of these claims. We asked KHPA claims staff to review the dates of death on another two claims.

The OIG recommends KHPA management strengthen the effectiveness of edits and audits and minimize overpayments. Specifically, (a) KHPA fee-for-service program managers should identify all required program and procedure limits and restrictions and ensure they have corresponding edits and audits in the MMIS and (b) the fiscal agent and KHPA claims staff should determine whether the current system testing is adequate to detect errors.

KHPA management agrees with these recommendations. (a) A review that focuses on the age and gender related edits has begun. Due to the number of edits and audits involved it is a lengthy process. (b) Although testing remains a key agency focus when implementing system changes, KHPA currently has no testing unit staff due to budget reductions and has limited capacity to perform this important function.

7. The OIG recommends KHPA management assign appropriate KHPA staff to review the list of exceptions or errors we have provided and identified, and where appropriate, initiate recoupment. Any edits not attached to specific procedure codes should be attached to prevent the same types of exceptions or overpayments in the future.

KHPA agrees with this recommendation. KHPA will direct HP to conduct a review of the claims process for age/gender restriction to identify any incorrect payments twice a year. According to KHPA staff, procedural instructions will be reemphasized with the processing staff to ensure continual education and understanding of Kansas program policies and guidelines. Additionally, KHPA will continue the weekly and annual reviews of the resolution edit/audit manual.

8. KHPA has not assessed damages on its fiscal agent for failure to meet data entry accuracy contractual requirements. The fiscal agent contractor must meet the following data entry standards: (a) for each claim type, 95 percent of all paper claims and (b) for each type of input, 95 percent of all prior authorization documents, all screening forms, and all other types of inputs entered by the fiscal agent must be free of data entry errors. Damages are set at \$500 per percentage point for each sample in which the accuracy rate falls below any of the above standards. The fiscal agent did not always meet this standard from FY 2004 to FY 2009. Had damages been imposed for every month in FY 2009 the fiscal agent was not in compliance with the data entry accuracy standards, damages would have amounted to \$3,500.

The OIG recommends KHPA management establish clear policies for the assessment of damages for failure to comply with contract accuracy standards and define criteria under which damage assessment on the fiscal agent for not meeting contractual accuracy standards will be imposed or waived. This policy would ensure consistency in decision making.

KHPA agreed with this recommendation and will develop a general guidance policy that will establish criteria under which damage assessments will be imposed or waived when a contractor fails to fulfill its contractual requirements.

In conclusion, the OIG's analysis confirmed that KHPA's system of controls provides assurance of compliance with federal and contractual requirements related to the timeliness and accuracy of claims processing. However, there are opportunities for further improvement. While we believe the resulting program savings would exceed the cost of implementing the recommendations, we recognize that current budgetary constraints and reduced staffing levels make it difficult for KHPA to implement additional control measures.

The KHPA OIG released this audit report on January 26, 2010. The complete report can be accessed on the KHPA OIG's website at <http://www.khpa.ks.gov/OIG/default.htm>.

INVESTIGATIONS

Investigation of Possible Hospice Provider Fraud

The OIG conducted a preliminary investigation of a Medicaid service provider.

The complaint alleged the provider has billed and been reimbursed by Medicaid for:

- Hospice services that were not necessary.
- Hospice services for which beneficiaries may not have been eligible.

At this writing, the OIG is working with the Attorney General's Medicaid Fraud Control Unit to plan the investigative work and assign appropriate staff resources.

OTHER ACTIVITIES

Current goals of the office include:

- Conduct other audits identified in the FY 2009 annual audit plan.
- Develop FY 2010 and FY 2011 audit plans that will allow the OIG to conduct audits of KHPA programs and operations, while preserving time for the OIG to be responsive to complaints from the public.
- Research allegations and complaints of fraud, waste, abuse and illegal acts and either conduct an investigation or review or complete preliminary research and refer the allegation to the appropriate agency or law enforcement.
- Ensure that KHPA OIG staff are properly trained as auditors and investigators, and have knowledge of the laws relevant to KHPA programs, as well as the methods for collecting the appropriate amount of creditable evidence of wrong doing, properly preserving that evidence and handing it off to appropriate agencies.
- Attend MFCU and other Program Integrity meetings and conference calls.
- Meet monthly with the MFCU director and KHPA SURS manager to discuss common issues.
- Maintain high ethical standards and work ethics in conducting audits, reviews and investigations.

FISCAL YEAR 2009 STATISTICS

K.S.A. 75-7427 requires this report include certain statistics from the previous state fiscal year for your information. The Office of Inspector General does not audit or evaluate the accuracy of the information below. The information has been submitted by the Kansas Department on Aging, Kansas Department of Social and Rehabilitation Services, Kansas Health Policy Authority and its fiscal agent, HP Enterprise Services.

Aggregate Information on Health Care Provider Sanctions

Three broad types of health care providers who provide services to the Medicaid program and the State Children's Health Insurance Plan (SCHIP) may be sanctioned for improper behavior: (1) nursing facilities and long-term care units; (2) providers contracting with managed care organizations (MCOs); and (3) fee-for-service providers, including those who provide services for Medicaid waiver participants. The reported statistics for each type of provider are found below.

- Sanctions of *nursing facilities and long-term care units* are handled by the Kansas Department on Aging (KDOA). KDOA staff report that in FY 2009, there were a total of 74 Medicaid only nursing facilities (NFs) of which 35 were long-term care units (LTCUs). In FY 2009 there were no terminations and four Medicaid Only nursing facilities that had Civil Monetary Penalties (CMPs) imposed; three were LTCUs and one was a nursing facility. Civil Monetary Penalties are generally imposed due to immediate jeopardy (IJ) existing for one or more residents, all IJs in FY 2009 were abated at the time of the survey.

There were a total of 53 surveys that resulted in non-compliance of which nine Denials of Payments on New Admissions (DOPNAs) were imposed on nursing facilities and long-term care units during this same time period, with an average of five days per DOPNA imposed. This means it took facilities found out of compliance an average of five days to be found back in compliance. DOPNAs are imposed for a wide range of issues in different areas found in providing nursing facility care which include: Resident Rights; Admissions; Transfer and Discharge Rights; Resident Behavior and Facility Practices; Quality of Life; Resident Assessment; Quality of Care; Nursing services; Dietary services; Physician services; Specialized Rehabilitation services; Dental services; Pharmacy services; Infection Control; Physical Environment or Administration.

- Sanctions of *providers credentialed by MCOs* are imposed by the MCOs with whom providers have a direct relationship. KHPA contracts with three MCOs to provide services for the Medicaid program and the State Children's Health Insurance Plan (SCHIP). KHPA staff report there were no sanctions against MCO-credentialed providers in fiscal year 2009 by KHPA.

Two other MCOs overseen by SRS provide care to Medicaid and SCHIP consumers. Sanctions of providers in these MCOs included the following:

- Two providers were placed on corrective action plans.
- Three providers were terminated or disenrolled.
- Two cases were forwarded to the Attorney General's Medicaid Fraud Control Unit (MFCU).
- Sanctions of *providers in the fee-for-service and waiver programs* are handled by KHPA staff, who report the following statistics for FY 2009:
 - Five providers were placed on "pre-pay review" status, which means before receiving payment; these providers are required to submit treatment records supporting the services provided. KHPA utilizes pre-payment review in cases in which questionable billing practices or poor documentation have been identified.
 - One provider has been terminated for cause by KHPA. A provider may be terminated for the reasons specified in KAR 30-5-60.
 - One provider was given a corrective action plan. A corrective action plan addresses both quality of care and quality and sufficiency of treatment records.
 - 45 beneficiaries were referred to SURS for "lock-in." Beneficiaries determined to be inappropriately using their medical card are restricted to assigned lock-in medical providers. Standard assignments for lock-in beneficiaries are a physician and a pharmacy. If emergency room or outpatient services have been used inappropriately, lock-in assignment includes a hospital.
 - 21 provider cases of suspected fraud were referred to the Kansas Attorney General's Medicaid Fraud and Abuse Unit for further investigation by the KHPA, HP Enterprise Services and the Managed Care Organizations.
- Four cases of suspected fraud were referred to MFCU for further investigation by the KHPA Office of Inspector General.

Aggregate Information on Provider Billing and Payments

KHPA's fiscal agent, HP Enterprise Services, formerly known as Electronic Data Systems (EDS), which processes claims for KHPA, reported processing over 18 million claims in FY 2009, which resulted in payments of \$2.58 billion. These numbers include payments to fee-for-service and waiver providers. In addition, \$383.65 million was paid in capitation payments to the three MCOs overseen by KHPA, who reported processing 2.66 million provider claims in FY 2009. The MCOs who contract with SRS report capitation payments of approximately \$199.72 million.

